ELM Pediatrics

New Patient Demographic Form

Child's Name: _____ Gender: ☐ Male ☐ Female
First *Middle* *Last*

Date of Birth: _____ Social Security # _____
(mm/dd/yyyy) *(Social Security Number)*

Home Address: _____
(Street) *(City)* *(State)* *(Zip)*

Demographic Information

My child's race is: (Please Check One)
☐ American Indian/Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White/Caucasian
☐ Other

My Child's ethnicity is (Please Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

My child's preferred language is: (Please Check One)
☐ English
☐ Spanish
☐ Other: _____
(Please Provide Preferred Language)

Mother/Guardian's Name: _____ DOB: _____ SSN: _____

Occupation: _____ Employer: _____

Home #: _____ ☐ *Preferred* Cell #: _____ ☐ *Preferred* Other #: _____ ☐ *Preferred*

Email Address: _____

Father/Guardian's Name: _____ DOB: _____ SSN: _____

Occupation: _____ Employer: _____

Home #: _____ ☐ *Preferred* Cell #: _____ ☐ *Preferred* Other #: _____ ☐ *Preferred*

Email Address: _____

Sibling's Names and Dates of Birth:

1. _____ DOB: _____ 2. _____ DOB: _____

3. _____ DOB: _____ 4. _____ DOB: _____

Primary Insurance:_____ Policy Number: _____ Group #: _____

Policyholder's Name: _____DOB: _____ SSN: _____

Secondary Insurance: _____ Policy Number: _____ Group #: _____

Policyholder's Name: _____DOB: _____ SSN: _____

Child's Birth and Development History

Born at (Name of Hospital): _____ Birth Weight:_____

Any Problems with pregnancy or delivery: _____

Full term birth? ☐ Yes ☐ No If No, how many weeks at birth? _____

Type of delivery (Please Check One): ☐ Vaginal ☐ C-Section NICU (Please Check One): ☐ Yes ☐ No

Hepatitis B Vaccine Date (if newborn): _____

Any chronic illnesses: _____

Any surgeries: _____

Current Medications: _____

Allergies (medicines, food, environmental): _____

Family History (Please Check Yes or No and explain if indicated)

Allergies/Asthma	☐ Yes	☐ No	If Yes, Please explain: _____
Diabetes	☐ Yes	☐ No	If Yes, Please explain: _____
Hypertension	☐ Yes	☐ No	If Yes, Please explain: _____
Convulsive Disorders	☐ Yes	☐ No	If Yes, Please explain: _____
Sickle Cell	☐ Yes	☐ No	If Yes, Please explain: _____
Cardiovascular Disease	☐ Yes	☐ No	If Yes, Please explain: _____

CONSENT FOR MEDICAL TREATMENT

THIS CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CHILD IS NO LONGER A MINOR

Who may bring the child in for appointments and consent to medical treatment (including vaccines) other than the legal parent/guardian?

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Phone: _____

Name of person filling out this form (printed): _____

Parent/Guardian Signature: _____ Date: _____